South Carolina
Continuation Application for
HIV Prevention Projects CY 2003
Announcement 99004

Cooperative Agreement No. U62/CCU402062-10-1

South Carolina Department of Health
And Environmental Control

STD/HIV Division

September 16,2002

TABLE OF CONTENTS

ATTACHMENTS:

HIV PREVENTION COMMUNITY PLANNING

1. NATIONAL COMMUNITY PLANNING CORE OBJECTIVES FOR CY2003

a. Foster The Openness And Participatory Nature Of The Community Planning Process

The following is a description of the current community planning group structure and any proposed changes during CY 2003. Also, incorporated is a description of the steps to be taken to foster the openness and participatory nature of the community planning process, including processes for recruiting new members, training new members, coordinating with Ryan White Titles I and II, and other methods used to obtain input from outside group membership.

Current CPG Structure:

There is one statewide community planning group in South Carolina. As mandated by the Centers for Disease Control and Prevention (CDC), the South Carolina Department of Health and Environmental Control (DHEC), Division of STD/HIV, established the South Carolina HIV Prevention Community Planning Group (CPG) in 1995. The maintenance of the CPG is also the responsibility of the Health Department. It is the role of the Executive Committee and the sub-committees listed below to fulfill the core objectives, principles and steps of community planning as outlined in the ***Guidance***.

According to the bylaws, the South Carolina HIV Prevention Community Planning Group shall consist of not more than 30 members. To date the CPG has twenty-nine (29) members. In 2002, the group traditionally met on the third Monday of each month, provided it was not a holiday, from 9:00 a.m. to 3:00 p.m. at the Clarion Town House Hotel and Suites in Columbia. Two (2) regional forums were scheduled for 2002. The Upstate HIV Prevention Regional Forum was held on May 20, 2002 at the Wilson World Hotel & Suites in Spartanburg, SC. A second regional meeting is scheduled for November 18, 2002 in Orangeburg County.

The Executive Committee is composed of seven (7) persons: one (1) administrator, one (1) DHEC (health department), Division of STD/HIV ex-officio member, one (1) DHEC (health department) co-chair, one (1) community co-chair, and three (3) members-at-large. Generally, the Executive Committee meets on the first Friday of each month from 9:00 a.m. – 3:00 p.m. at Capitol Consultants, Inc. in Columbia. This body is responsible for providing overall direction of the statewide community planning group and assigning tasks to appropriate committees as needed.

At the 2002 annual retreat, the committees were restructured again. Currently, there are ten working committees, patterned after Iowa's community planning group committee structure. They are 1) Executive Committee, 2) Membership Committee, 3) Needs Assessment Committee, 4) Technical Assistance and Evaluation Committee, 5) Youth Committee, 6) Behavioral and Social Science Committee, 7) Public Relations and Marketing Committee, 8) Epidemiology Committee, 9) South Carolina HIV Prevention Community Planning Leadership Summit Planning Committee, and 10) HIV Prevention Regional Forum Planning Committee. Committee membership is open to any individual interested in preventing the spread of HIV in South Carolina.

Recruiting New Members:

In accordance with the bylaws, the Membership Committee is comprised of five CPG members. The Executive Committee appoints the Chair of the Committee, and the CPG elects the other four members. Currently, the Committee consists of two (2) African American females and three (3) White males, one of whom is HIV positive. The Committee is responsible for screening the applications, interviewing applicants, and presenting the list of new members to the CPG Co-Chairs, who review the selection process for adherence to the procedure, and then to the CPG for approval.

Each year the Membership Committee conducts a survey to determine how many members would like to continue to serve on the CPG. Members are retained if they express a desire to remain active; if they want to discontinue their membership, members are asked to complete an exit survey. From the list of returning members, membership gaps are determined. The Membership Committee and CPG members are encouraged to be proactive in soliciting candidates for membership that are in alignment with the gaps and *CDC Guidance, Principles of HIV Prevention Community Planning, #5.* The By-Laws and Policies and Procedures instruct the CPG and DHEC to use a variety of methods to publicize the nomination and selection process including: mailings to newsletter lists, churches, organizations, housing projects, minority and neighborhood newspaper ads, and personal contacts. The CPG application is also available on the DHEC STD/HIV Division website.

Nominations for membership are solicited through the open process mentioned above and candidates are selected, based on criteria that have been established by the health department and the community planning group. An individual can self-nominate or nominate others by completing an application and submitting it to the CPG administrator. The applications provide information about the knowledge, experience, expertise, and personal and organizational affiliations of the nominee. The goal is to obtain more applications than vacancies.

In previous years, members were added annually, during the months of November and December, after the plan and application have been submitted to CDC. However, potential members were encouraged to attend and participate in CPG meetings throughout the year in a non-voting capacity. At the urging of the CDC, the CPG agreed to pilot test accepting new members as vacancies occurred throughout the year. Thus far this practice has proven to be challenging to the planning process because new members that joined after March 2002 missed the annual planning retreat, and as a result were not familiar with the details of the planning steps. Often, much time was taken up during meetings to explain procedures. However, the Membership Committee will evaluate this practice at the end of the year and make a recommendation to the Executive Committee whether or not to continue.

Training New Members:

Parity is defined as the condition whereby all members of the HIV prevention community planning group are provided opportunities for orientation and skills building to participate in the planning process and to have an equal voice in voting and other decision-making activities. In order to achieve parity, the South Carolina HIV Prevention Community Planning Group will continue to provide new member orientation, offer training at CPG meetings and monthly workshops, and support participation in state and national conferences.

All members of the CPG are offered a thorough orientation, as soon as possible after appointment. The CPG conducts a one-day new member orientation class. The goal of the new member orientation and the annual retreat is to prepare members to participate fully in the community planning process. In conjunction with the information outlined in the *CDC Guidance, Principle of HIV Prevention Community Planning, #8,* the agenda for new member orientation includes a knowledge test on HIV/AIDS/STI and viewing the videocassette tape entitled "HIV Prevention Community Planning: Partners in Prevention Community Planning Overview". This is followed by a review of the historical perspective of community planning in South Carolina, the CPG's governing documents such as the CDC Guidance, bylaws, and policies and procedures. At the conclusion of the orientation the training staff entertains questions, and new members complete evaluation forms so that improvements can be made to the next class.

Additionally, each new member is paired with an existing CPG member who serves as a "mentor". Mentors are available during meetings and other events to educate and explain the planning procedures and other information new members may need. The mentor process will continue during 2003.

Skills building training is provided throughout the year for both new and existing CPG members to enhance their ability to participate in the planning process. The Technical Assistance and Evaluation Committee uses the meeting evaluation forms to select topics and schedule trainings at regularly scheduled CPG meetings or workshops. Periodically, workshops and satellite broadcasts are coordinated by DHEC Division of STD/HIV based on needs expressed by CPG members, as well as HIV Prevention Collaborations and public health department personnel.

A scholarship process was established to give members an opportunity to participate in national conferences such as the National HIV Prevention Conference and United States Conference on AIDS. Attendance to the National Community Planning Leadership Summit for HIV Prevention is usually limited to the Co-Chairs and/or Executive Committee members due to cost.

Coordinating with Ryan White Titles I and II:

South Carolina has services funded with Ryan White Title II, III and IV funds**.** Efforts to coordinate planning include:

- Sharing the CPG's epi profile for care services planning and sharing care services needs assessment data with the CPG (and vice versa).
- Title IV pediatric staff routinely attend CPG meetings which provides coordination with planning several efforts targeting African American youth at risk and women.
- Several CPG members attend Ryan White care provider quarterly meetings, participated in the updating of the HRSA-required Statewide Coordinated Statement of Need which includes a component on linking prevention and care services, and are participating in the cross-Title development of the Comprehensive HIV Care Plan during 2002 and 2003.

Methods Used to Obtain Input from Outside Group Membership:

Below are the methods used to obtain input from the South Carolina HIV Prevention Collaborations and community individuals.

Local HIV prevention collaborations were created in 1995 for the purpose of increasing local community involvement and capacity building. There are currently eleven collaborations. Collaborations include several partners such as AIDS service organizations, alcohol and drug abuse facilities, churches, schools, youth groups, mental health agencies, local health departments, etc. The lead organization, or contractor, receives the funds on behalf of the group, but the Collaborative members partner together to develop and implement local plans using the population and intervention priorities identified in the state comprehensive HIV prevention plan written by the CPG.

In the past, in an effort to improve communication between the collaborations and CPG members, the CPG invited HIV prevention collaboration lead agencies to submit the name of a person they would like to represent them at the CPG meetings. The representatives were called SC HIV Prevention Community Planning Group Liaisons. Their duties were to attend and participate in all CPG meetings, and communicate what transpired at the CPG meetings with their local Collaborations. There were eleven (11) liaisons. Five (5) served in a dual role as a CPG member and liaison. The remaining six (6) were liaisons only.

In 2001, the South Carolina HIV Prevention Collaboration Ad Hoc Workgroup was established to make recommendation(s) to the CPG whether or not to continue with the practice of liaisons. The workgroup consisted of a few members from the CPG Executive and Membership Committees and liaisons. The ***Guidance*** stated that "representatives who are included in the [community planning] process can participate equally in the decision-making process." This was not the case with liaisons, which were not CPG members, because they could not vote and did not receive equal compensation. Therefore, the liaison structure violated the principle of "parity", and the CPG voted to discontinue utilizing the liaisons.

The recommendations that were submitted by the ad hoc workgroup are below.

a) Maintain the current structure of the CPG as outlined in the ***Guidance***,
b) Expand the committee structure to include SC HIV Prevention Collaborations and community persons.
c) Revise the language in the bylaws and the policies and procedures to read "actively recruit SC HIV Prevention Collaborations", and
d) Revise committee structure to include: 1) Executive Committee, 2) Membership Committee, 3) Needs Assessment Committee, 4) Technical Assistance and Evaluation Committee, 5) HIV Prevention Regional Forum Planning Committee, 6) Behavioral and Social Science Committee, 7) Public Relations and Marketing Committee, 8) Epidemiology Committee, 9) South Carolina HIV Prevention Community Planning Leadership Summit Planning Committee, and 10) Youth Committee.

On February 11, 2002, the CPG voted to accept the above recommendations. The new committee structure now allows the public to participate on the CPG committees which furthers enhances the input obtained from outside group membership.

In effort to strengthen youth representation and participation, the CPG established a Youth Committee. The purpose of this committee is to ensure inclusion and representation of youth in the community planning process. "Youth" is defined as persons under the age of 19.

In 2002, the CPG will host two HIV prevention regional forums. One was held in Spartanburg County and the other will take place in Orangeburg County. The CPG worked in concert with the local health department, collaboration and community advocates to plan the forums. This body was referred to as the Planning Committee, and their purpose was to assist with the logistics such as who should be invited, where should the forum be held, when is the best date and time to have the forum, etc. Additionally, the Planning Committee helped develop the program format and advertised the event. They told us about the HIV educational needs of their community, and a program was designed based on the identified informational needs.

Many CPG members attend the collaboration lead agency and HIV/AIDS/STD Health Educators meetings, in conjunction, with the Health Department Co-Chair, to inform the collaborations and health department personnel of upcoming CPG events and activities.

The South Carolina HIV Prevention Community Planning Leadership Summit (CPLS) was also designed to enhance communication between HIV prevention consumers and providers, specifically through the use of town hall meetings and networking luncheons. Planning has begun for the third annual CPLS to include an HIV prevention educational legislative breakfast. DHEC has submitted a letter of intent to CDC for Program Announcement 001025 requesting financial assistance with the conference.

Proposed Changes for 2003:

1. The Membership Committee will evaluate the practice of accepting members as vacancies occur, evaluate the process for providing new member orientation on an ongoing basis, and make a recommendation whether or not to continue these practices.

2. The Executive Committee will identify and invite other regions of the state to host HIV prevention regional forums in 2003. Consideration will be based on feedback from participants of the regional forums, as well as other community "town hall" meetings held by other prevention partners, membership gaps, epi profile data by region, etc.

3. The Public Relations and Marketing Committee will evaluate and design marketing tools to target and recruit additional collaboration and community persons to participate in the community planning process. These may include flyers, promotional items, brief announcements to be integrated in community events, posters in key community sites reaching priority populations, etc. Items will be shared with CPG members, local prevention and care providers to be distributed in 2003.

4. The Membership Committee and CPG Administrator will address efforts to improve new member recruitment, orientation and training, and CPG member retainment. These will include:
   - Developing a job description for "mentors";
   - Developing a new member packet;
   - Establishing guidelines for Friends of the CPG;
   - Writing a letter to accompany the CPG membership application informing interested persons that requested personal information is confidential and to not let that discourage them from completing the application;

- Reviewing the Attendance Policy and making recommendations for changes to the Executive Committee and CPG; and
- Revising the Exit Survey Form and conducting exit interviews.

5. Maintain community planning website with linkages to active committees, CPG Plan, dates of CPG meetings, membership applications, etc.

6. Continue coordination of planning efforts between Ryan White Care Titles II, III, IV and Section F planning committees and HIV prevention community planning through participation at meetings, presentations, sharing planning and program information.

b. Ensure That The Community Planning Group (CPG) Reflects The Diversity Of The Epidemic And That Expertise In Epidemiology, Behavioral Science, Health Planning, And Evaluation Are Included In The Process

This section will briefly discuss the extent to which the CPG membership reflects the epidemic in the jurisdiction in terms of gender, age, race/ethnicity, and exposure category using information from the membership grid.

In order to achieve representation, the By-Laws and Policies and Procedures instruct the Executive Committee to review the composition of the CPG membership on an annual basis and make recommendations to the Membership Committee and the CPG on the priority characteristics needed when filling vacancies. The Executive Committee developed a SC HIV Prevention Community Planning Group Membership Worksheet to view the CDC Guidance requirements for membership, epidemiologic profile, actual membership, and gaps in membership at-a-glance. Below is the worksheet developed for prioritizing 2002-2003 membership needs.

CDC GUIDANCE Representation of the community planning group includes: **Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of …**	**SC EPIDEMIOLOGIC PROFILE**	**ACTUAL MEMBERSHIP As Of August 2002 (N=29)**	**MEMBERSHIP GAPS**
Age	No. (%) of Total Persons Living with HIV/AIDS, 2001 < 19 = 637 (5%) 20-24 = 1644 (14%) 25-29 = 2271 (19%) 30-49 = 6,535 (56%) 50+ = 740 (6%)	No. (%) <19 = 0 20-24 = 2 (7%) 25-29 = 2 (7%) 30-49 = 16 (55%) 50+ = 9 (31%)	Increase representation of youth (<19 years of age)

CDC GUIDANCE Representation of the community planning group includes: **Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of …**	**SC EPIDEMIOLOGIC PROFILE**	**ACTUAL MEMBERSHIP As Of August 2002 (N=29)**	**MEMBERSHIP GAPS**
Gender	No. (%) of Total Estimated Living with HIV/AIDS, 2001 Male = 8,288 (70%) Female = 3,522 (30%) (No data available for transgender population)	No. (%) Male = 13 (45%) Female = 15 (52%) Transgender = 1 (3%) Unknown = 0	Increase the # of males
Race/Ethnicity	No. (%) of Total Persons Living with HIV/AIDS, 2001 Black or African American (Not Hispanic) = 73% White or Caucasian (Not Hispanic) = 25% Hispanic or Latino = 2% Note: 3% of new cases reported in 2001 were Hispanic	No. (%) Black or African American (Not Hispanic) = 27 (69%) White or Caucasian (Not Hispanic) = 7 (24%) Hispanic or Latino = 2 (7%)	Investigate the inclusion of Asian/Pacific Islanders and Native Americans/Alaskan Natives
Socioeconomic Status	<$10,000 = 38% >$10,000 = 62%	No. (%) <$10,000 = 2 (7%) >$10,000 = 27 (93%) ***** OR ***** <$10,000 = 2 (7%) $10,000-$14,999 = 3 (10%) $15,000-$24,999 = 1 (3%) $25,000-$34,999 = 5 (17%) $35,000-$49,999 = 13 (45%) $50,000-$74,999 = 5 (17%) >$74,999 = 0	
Geographic and Metropolitan Statistical Area (MSA) – Size Distribution (Urban and Rural Residence)	About half (54%) of persons living with HIV live in larger urban MSA's (Columbia; Charleston; Greenville-Spartanburg-Anderson, and York (Charlotte). But, 46% live in all other counties—in particular Sumter, Florence, Orangeburg, Horry, Beaufort. Among new cases in 2001, 53% were in larger urban MSA's, 47% rural.	No. (%) Urban Metropolitan Area = 13 (45%) Urban Non-Metropolitan Area = 6 (21%) Rural Area = 10 (34%)	Ensure maintenance of urban, urban metropolitan area, and urban non-metropolitan representation

CDC GUIDANCE Representation of the community planning group includes: **Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of …**	**SC EPIDEMIOLOGIC PROFILE**	**ACTUAL MEMBERSHIP As Of August 2002 (N=29)**	**MEMBERSHIP GAPS**
Risk for HIV Infection	Proportion of Persons Living with HIV/AIDS by Risk Exposure, 2001 MSM = 32% Heterosexual = 26% IDU = 12% Other (blood transfusions, hemophilia, perinatal transmission) = 2% No Risk Identified = 28% From 1991-2001, the number of persons living with HIV/AIDS increased by 126%.	No. (%) MSM = 8 (28%) MSM/IDU = 1 (3%) IDU = 1 (3%) Heterosexual = 18 (62%) Mother with or at risk for HIV infection = 0 General Public = 0 Unknown = 1 (3%) Living with HIV/AIDS = 5 (17%)	Increase the number of IDU Continue to recruit persons living with HIV/AIDS
Staff of state and local health departments, including HIV Prevention and STD treatment programs; staff of state and local education agencies; and staff of other relevant governmental agencies (e.g., substance abuse, mental health, corrections)	Epidemiologic profile does not reflect this information	State Health Department = 2 Office of Minority Health = 1 Local Health Department = 4 Substance Abuse = 2 Mental Health = 1 Department of Corrections = 1 Community Long Term Care = 1 Academic Institution = 1	Investigate the inclusion of the State Department of Education, Department of Social Services, and Department of Juvenile Justice
Experts in epidemiology, behavioral and social sciences, program evaluation, and health planning	Epidemiologic profile does not reflect this information	Epidemiologist = 0 Behavioral or Social Scientist = 7 Evaluation Researcher = 0 Intervention Specialist = 3 Health Planner = 1 Community Representatives = 9 Other = 9	Investigate strategies for inclusion of an epidemiologist and evaluation researcher Request CDC define representation categories on the membership grid Absence of definition for "other"
Representatives of key non-governmental and governmental organizations providing HIV prevention and related services (e.g., STD, TB, substance abuse prevention and treatment, mental health services, homeless shelters, HIV care and social services) to persons with or at risk for HIV infection	Epidemiologic profile does not reflect this information	HIV Prevention Collaborations = 9 AIDS Service Organizations = 2	Investigate the inclusion of the youth serving organizations such as teen pregnancy prevention council

CDC GUIDANCE Representation of the community planning group includes: **Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of …**	**SC EPIDEMIOLOGIC PROFILE**	**ACTUAL MEMBERSHIP As Of August 2002 (N=29)**	**MEMBERSHIP GAPS**
Representatives of key non governmental organizations relevant to, but who may not necessarily provide, HIV prevention services (e.g., representatives of business, labor, and faith communities)	Epidemiologic profile does not reflect this information	Faith Community = 2 Minority Board CBO = 3 Non-minority Board CBO = 4 Other Nonprofit = 4	Investigate the inclusion of business and labor

The epidemiologic profile clearly demonstrates that the concentration of the infection is greater in sexually active, African American, males, ages 30 – 49 years. Among the new cases HIV in 2001, 53% were in larger urban metropolitan statistical areas and 47% rural. The Membership Committee will continue to ensure that the CPG is reflective of the epidemic.

The information used to complete the "Actual Membership" column was extracted from the Community Planning Group membership profiles of 29 current members as of September 2002. Based on the worksheet above, comparing actual membership to the epi profile data the following are priority membership needs for 2002:

- Youth,
- Males,
- Expertise of an epidemiologist and evaluation researcher,
- Non-governmental agencies, particularly youth serving, and
- State agencies, particularly Department of Education, Department of Social Services, and Department of Juvenile Justice.

The Executive Committee has directed the Membership Committee to develop a 2003 action plan that will address the gaps listed above and develop and implement strategies for filling them.

Proposed Changes for 2003:

1. Solicit applications from epidemiologists from colleges/universities, professional associations, and other DHEC programs.

2. Explore options to increase youth participation, such as establishing a Youth Advisory Committee.

3. Membership Committee will continue to review composition of the CPG on a regular basis and determine priority membership needs.

c. Ensure That Priority HIV Prevention Needs Are Determined Based On An Epidemiologic Profile And A Needs Assessment

The following describes plans for updating or modifying the epidemiologic (epi) profile and needs assessment during CY 2003.

Epidemiologic Profile

DHEC staff and the Epidemiology Committee are currently completing an updated Epi Profile using the same format as the current profile. The current profile has data through 1998, the updated version has data through 2001. Any modifications to the updated profile will be made based on input from epidemiologists and other experts, as well as any additional data obtained on behavioral and seroprevalence estimates among priority populations. The updated epi profile is scheduled to be completed by November 2002 and will be shared with the CPG by December 2002. The CPG will review the Epi Profile and current priority populations and make adjustments as needed in 2002, particularly for African American Men who have Sex with Women – a population currently unranked.

In the 2001 planning period, the CPG made recommendations to expand surveillance efforts to include enhanced behavioral and seroprevalence estimates among priority populations. As resources allow, efforts to obtain these estimates will occur in 2003, and the Epi Profile will be amended when data becomes available.

DHEC is expected to receive supplemental CDC HIV Surveillance funds to enhance staff capacity to develop an updated, consolidated epi profile for prevention and care providers in the state. It is also expected that the professional staff person hired with these funds will develop local, regional epi profiles that will assist the CPG in assessing populations and prevention needs by geographic area. The local profiles will also assist local prevention and care providers with planning and evaluation efforts. These activities will occur in 2003.

Phase II Needs Assessment

Planning for Phase II of the needs assessment began June 2001 with regular conference calls with the Needs Assessment Committee and Academy of Educational Development. A town hall meeting was held at the 2002 South Carolina HIV Prevention Community Planning Leadership Summit (CPLS) to focus on Phase I and II of the CPG needs assessment. The town hall meeting was divided into two parts. Part I consisted of explaining why we need to do needs assessment and how the information will be used; reviewing Phase I needs assessment outcomes; and providing an overview of future CPG needs assessment plans. Additionally, summit participants provided input into Phase II of the needs assessment through small group work (assigned by priority population) facilitated by AED staff. The Needs Assessment Committee documented each group's report.

On January 21-22, 2002, the Needs Assessment Committee, with assistance from AED, was charged with taking the information collected at the CPLS and developing a long-term needs assessment action plan. A Needs Assessment Coordinator was hired to implement Phase II of the action plan, specifically the focus group and key informant interviews. Several population focus groups are expected to be complete by December 2002; all are expected to be complete by

summer 2003. It was determined that interviews would be the preferred method to obtain information from injecting drug users; these interviews are expected to be complete by early 2003.

Once Phase II and III of the needs assessment have been completed, this information will be used to update the Plan, Chapter 2: Needs Assessment, Resource Inventory, Gap Analysis.

Proposed Changes for 2003:

1. DHEC will develop a consolidated Epi Profile for prevention and care planning by the end of CY 2003. Regional epi profiles will also be completed to assess differences among populations impacted by geographical area.

2. The Epi Profile data indicate an apparent decline in the number of new HIV infections diagnosed among injecting drug users (all racial populations). During 2003, DHEC will attempt to validate this apparent trend with seroprevalence surveys among injecting drug users in both community and treatment settings. If the prevalence estimates confirm a declining trend/lower proportion of total HIV cases attributed to IDU risk, the CPG will also re-examine the definition of "disproportionate impact" as a factor for during the next priority setting process.

3. Complete Phase II needs assessment activities to include focus groups, interviews, surveys, and literature review depending on resources and the specific population; assessments will be completed by July 2003.

4. Using results from the Phase II population needs assessment, the Needs Assessment Committee will initiate **Phase III** assessments during 2003. Phase III assessment will involve round table discussions with representatives of each priority population to further explore and define key findings related to risk behaviors, social context and HIV prevention needs. Discussions will focus on obtaining further insights and recommendations of behaviors and prevention strategies. Information will be used for priority setting in 2004.

5. An updated Resource Inventory will be completed during 2003. Sources of information will include CDC required process evaluation data from funded prevention providers, provider telephone surveys, and the Statewide HIV/AIDS Resources and Information Guide (SHARING). To improve the quality of the resource inventory process evaluation data, DHEC staff will develop standard definitions of interventions and target populations, conduct training and periodic reviews of reported process evaluation data to improve the gap analysis process.

6. Priority setting of populations and interventions will occur during 2004 using similar process as 2000 according to the technical assistance received by CDC/AED.

d. Ensure That Interventions Are Prioritized Based On Explicit Consideration Of Priority Needs, Outcome Effectiveness, Cost Effectiveness, Social And Behavioral Science Theory, And Community Norms And Values

The CPG utilized the Behavioral and Social Science Volunteer Program to identify a local scientist that would be willing to work with the CPG to help prioritized interventions. Dr. Leonard Goodwin a professor at South Carolina State University Department of Psychology and Sociology was identified and agreed to co-chair the Behavioral and Social Science (BSS) Committee in conjunction with another CPG member. The purpose of this committee is to facilitate the prioritization of interventions and strategies for each high risk population identified. The committee used a document entitled "Fact Sheets of Effective HIV Prevention Interventions" to identify effective interventions for priority populations selected by the CPG. In 2003, the BSS Committee will develop and implement an action plan to prioritize interventions.

Tracee Belzle with the Dallas STD/HIV Behavioral Intervention Training Center HETCAT attended the CPG Annual Retreat in March 2002 and provided a full day of instruction on HIV/STD interventions to the entire membership. The course explored the importance of adopting and/or incorporating behaviorally based interventions to meet the needs of our clients.

The South Carolina HIV Prevention Collaborations were asked by the CPG to participate in two important programs: 1) the 2002 South Carolina HIV Prevention Community Planning Leadership Summit (January 2002) and 2) Upstate HIV Prevention Regional Forum (May 2002). These programs were designed to educate the CPG and community on the type of interventions currently available in state for priority populations. The CPG will continue to offer similar presentations in 2003.

The current HIV Prevention Plan recommends that DHEC design and train prevention providers on standardized definitions of health education/risk reduction and other interventions. The purpose is to improve the quality of process evaluation data needed to conduct the resource inventory and gap analysis. In January 2002, the STD/HIV Division formed a Health Education/Risk Reduction Quality Assurance Ad Hoc Committee to develop definitions and standards for each of the intervention types. The committee is made up of health department staff and collaboration representatives, including one who is a CPG member. Members of this committee attended and provided a brief presentation at the CPG Annual Retreat.

Proposed Changes for 2003:

1. The CPG has determined that the interventions will be prioritized in rank order after obtaining specific South Carolina target population input during Phase II and III of the Needs Assessment. During 2003, the CPG will revisit and discuss priority interventions to determine if additional interventions should be included for each population prior to making significant shifts in funds. The current priority interventions may not be realistic for some populations. For example, Outreach and Individual Level interventions may be more appropriate for injecting drug users (than Group level) because of the stigma and criminalization of injecting drug use in South Carolina. Similarly, the priority intervention for African American Men Who Have Sex with Men (Group level) needs to be broadened also due to stigma making it difficult to recruit MSM to participate in group level

interventions. The CPG acknowledges that for the next priority setting process greater attention needs to given to CDC funded and community norms and values as factors (and how to define these factors) for selecting priority interventions.

2. Develop priority interventions for African American men who have sex with women during the next prioritization process (during 2002-2004).

3. Develop and implement an action plan to prioritize interventions to include updating and reviewing additional literature and summarizing results of the Phase II needs assessment by target population to prepare for updating the prioritization of interventions.

e. Foster Strong, Logical Linkages Between The Community Planning Process, The Comprehensive HIV Prevention Plan, The Application For Funding And Allocation Of CDC HIV Prevention Resources

The overall linkages between the community planning process, priority setting process, and plans for implementation in this application for funding, and the allocation of CDC HIV prevention resources are described below. Table 1 on page 14 summarizes the linkages by listing the 2003 Application proposed populations and interventions, estimated amount of 2003 resources allocated by population, 2002 – 2004 SC HIV Prevention Plan Priority populations and interventions, and the 2002 Epi Profile new case and prevalence case proportions by population.

Table 1 shows consistency between the priority populations ranked by the CPG and those proposed in the 2003 application. All are consistent with the proportional impact of the HIV/AIDS epidemic in South Carolina except for African American Men Who Have Sex with Women, who comprise 18% of new cases during 2000 – 2001 and 12% of persons estimated to be living with HIV at the end of 2001.

African American Men Who Have Sex with Women population was added in 2001 by the CPG as a priority population for needs assessments based on reviewing the Epi Profile. The CPG will rank this population by December 2002 upon review of additional epi profile data; this ranking will result in more complete consistency between the priority populations and proposed interventions in the application and the Epi Profile data.

During the Gap Analysis review and discussion by the CPG in 2001, there was an apparent potential gap for all priority HE/RR interventions for each population. The majority of funds/providers for each population were targeted for other interventions such as outreach, individual, health communications/public information.

To address the apparent gaps, the CPG recommendations stated in the updated 2002 – 2004 Plan for redirecting resources include:

- Allocate new/supplemental funding toward African American Men Who Have Sex With Men, Group Level Interventions.
- Redistribute focus within collaborations to priority interventions, less on Health Communications/Public Information and other categories.
- Commit technical assistance/capacity building efforts to identify and apply for funding

from other sources.

- Commit technical assistance/capacity building efforts to provide training to local staff to ensure they have skills to provide priority interventions according to standards of practice.
- Ensure substance abuse agencies are included in collaborations to address injecting drug user populations.

The 2003 application for funding is based on the Epi Profile, CPG's priority populations and interventions and it incorporates the above recommendations. The prioritized interventions for each population are Health Education/Risk Reduction; in addition, community delivered HIV counseling and testing services are recommended in the Plan for each population. An estimated 76% of the Health Education/Risk Reduction funds budgeted in the 2003 Application is directed for the priority populations/interventions listed in Table 1. This estimate is based on the 2002 local implementation plans submitted by local collaborations/contractors. The remaining 24% of funds are directed to "general population" and/or other interventions, primarily health communications/public information.

Table 1. Linkage Between The Application, The Plan and the EpiProfile

2003 Application Proposed Populations and Interventions	Estimated HE/RR Funding Proportion & Amount To be Allocated with 2003 Funds	2002-2004 SC HIV Prevention Plan Priority Populations (Ranked) & Interventions (Unranked)	2002 Epi Profile	
			2000/2001 Diagnosed HIV/AIDS Cases by Pop. % of Total Cases w/Risks (1,201)	Persons Living with HIV/AIDS, 2001 By Pop. % of Total Cases w/Risks (8,535)
1. African Amer. MSM, 15 – 44 (**GLI**, **CBC&T, CLI**, HC/PI, PCM, OTR)	28% ($314,372)	1. African Amer. MSM, 15 – 44 (**GLI, CBC&T**, **CLI**)	22%	25%
2. African Amer. WSM, 15 – 44 (**ILI, GLI, CBC&T,** HC/PI)	39% ($433,337)	2. African Amer. WSM, 15 – 44 **(ILI**, **GLI**, **CBC&T**)	23%	19%
3. White MSM, 15-44 (**GLI, ILI,** CBC&T, OTR, HC/PI)	6% ($65,852)	3. White MSM, 15 – 44 (**GLI, ILI)**	15%	19%
4. African Amer. Male IDU, 20 – 44 (**ILI, GLI, OTR, CBC&T)**	5% ($52,119)	4. African Amer. Male IDU, 20 – 44 (**ILI, GLI, OTR, CBC&T)**	7%	9%
5. African Amer. Female IDU, 20 – 44 **(ILI, GLI, OTR, CBC&T)**	3% ($29,151)	5. African Amer. Female IDU, 20 – 44 (**ILI, GLI, OTR, CBC&T)**	3%	4%
6. White Male IDU, 20 – 44 **(GLI, OTR,** ILI)	4% ($38,868)	6. White Male IDU, 20 – 44 (**GLI, OTR,** CBC&T**)**	1%	2%
(Unranked) African Amer. MSW (GLI, CBC&T, ILI**,** CB**,** OTR**,** HC/PI**)**	**19% ($209,684)**	**(Unranked) African Amer. MSW (GLI, CBC&T,** CLI**)**	**18%**	**12%**

NOTES:

1. Populations: MSM = Men who have Sex with Men; WSM = Women who have Sex with Men; IDU = Injecting Drug User; MSW = Men who have Sex with Women
2. Interventions: ILI = Individual Level; GLI = Group Level; CLI = Community Level; PCM = Prevention Case Management; OTR= Outreach; CBC&T = Community Based Counseling and Testing; CB = Capacity Building; HC/PI = Health Communications/Public Information.
    - **Bolded** interventions indicate consistency between Application and Plan.
3. Epi Profile Data: Based on number of persons with known risk.

The proposed funding allocations by population and intervention type is essentially representative of the Epi Profile. However, since the supplemental funding was awarded to address gaps identified in 2001 to target African American MSM, the 2003 proposed funding proportions reflect a lower proportion of funds for white MSM. There is a higher proportion of funds targeting African American heterosexual women than reflected by the Epi Profile.

Proposed Changes for 2003:

1. In 2003, DHEC will continue its efforts to more accurately assess the capacity of the funded prevention system to deliver priority interventions to priority populations described in this application. Local implementation plans will be reviewed and monitored to ensure priority populations and interventions are being implemented. This will also include working with contractors (collaborations) and local health departments to clarify the definition of intervention types to ensure consistent reporting. Full implementation of the Intervention Monitoring System during 2003 will also provide the community planning group with more accurate data about interventions delivered with cooperative agreement funds especially in terms of geographic availability, client demographics, intervention types, and estimated resources allocated for each. This will improve the quality of the data and ability to show linkages between the Plan, Application and resource allocation. (See Evaluation Plan in this Application for more detailed of the Intervention Monitoring System).

2. If additional funds become available, DHEC will address the apparent gap areas specified in the Plan. Priority will be given to supporting those interventions that were shown to be effective and appropriate within the target populations as indicated by the needs assessment.

2. COMPREHENSIVE HIV PREVENTION PLAN

One jurisdiction-wide, multi-year HIV prevention plan is attached. The 2002-2004 South Carolina HIV Prevention Plan has been completely revised. The CPG will develop a plan to strategically review and update the plan by 2004. The plan may be also be found at the following website: www.scdhec.net/HS/diseasecont/stdwk/html.

B. HIV PREVENTION PROGRAM

1. 2003 PROGRAM GOALS, OBJECTIVES, AND ACTIVITIES

a. Target Populations And Interventions

The table below describes by target population (shaded areas) the linkages between priorities in the SC HIV Prevention Plan for 2002-2004 and the 2003 application for funding. In the first column of the table includes descriptions of priority interventions identified in Chapter 3 of the Plan. Column two presents descriptive information about the types of interventions that will be funded in 2003 that match the recommendations in the plan.

Column three presents descriptive information about any interventions and activities that will be funded that do not match a recommendation in the current priority setting process and the plan.

Recommendations in the Plan	Interventions Proposed in the CDC Funding Application	
	…that match a recommendation in the plan	**…that do not match a recommendation in the plan**
Target Population #1: African American Men who have Sex with Men (MSM) Ages 15 - 44		
Priority Interventions: Group Level Interventions (GLI): Provide multi-session group education/counseling programs in accessible community settings. Proven-effective or theory-based curricula should be used. Peer and Non-peer provided counseling, risk reduction skills training and social support.	**Priority Interventions:** 2 Collaborations will provide multi-sessions; in which one collaboration will use the Partners in Prevention program. 1 collaboration will conduct group level interventions using multi-session, skill-based activities conducted by lead agency and American Red Cross staff and Clergy Taskforce members in community center settings. With CDC supplemental funds, 1 CBO will conduct GLIs using the American Red Cross African American Prevention Skills Program. With CDC supplemental funds, 1 CBO will conduct GLIs within a framework of a "Men's Health Initiative" program to reach both identified and non-identified MSM. With CDC supplemental funds, 3 CBOs will provide GLIs with multi-session, skills building for AAMSM who are PLWHIV.	Collaboration will conduct focus group to assist in creation of culturally-sensitive messages (CB) Collaboration will utilize the media to target specific HIV prevention messages (HC/PI) 2 collaborations will conduct outreach: 1 providing prevention information to be disseminated bi-monthly by peers in MSM-identified bars; and 1 "Community PROMISE" curriculum-trained peer outreach workers who will deliver prevention messages (role model stories). 1 collaboration will provide individual counseling by collaboration staff. With CDC supplemental funds, 1 CBO will conduct HC/PI to market and recruit participants into the "Men's Health Initiative" program. With CDC supplemental funds, 2 CBOs will provide individual counseling and/or PCM to AAMSM who are PLWHIV.
Other Recommended Interventions: Community–Level Interventions (CLI)	With CDC supplemental funds, 2 CBOs will conduct a CLI for AA MSM using a modified version of the "Popular Opinion Leader" curriculum.	
Community Based Counseling & Testing (CBC&T)	1 collaboration will utilize lead agency staff and community peer educators to offer CBC&T. 1 Collaboration will provide OraSure testing at various community sites (CBC&T)	.

Recommendations in the Plan	Interventions Proposed in the CDC Funding Application	
	…that match a recommendation in the plan	**…that do not match a recommendation in the plan**
Target Population #2: African American Women who have Sex with Men (WSM), Ages 15 -44		
Priority Interventions: Individual Level Interventions: Provide individual level counseling in community and clinic settings. Client-centered counseling skills be demonstrated to provide behavioral skills training, safer sex negotiation	2 Collaborations will provide individual sessions in community settings to help client identify risk and develop a RR plan. 2 collaborations will provide individual prevention counseling in community settings.	
Group Level Interventions: Provide group level, multi-session education /counseling in accessible community settings. Proven-effective or theory-based curricula should be used. Peer and Non-peer provided counseling, risk reduction skills training and social support.	4 Collaborations will provide sessions focusing on HIV prevention education, gender pride, negotiation, condom and communication skills and building healthy relationships at various community locations such as detention centers, women shelters, etc. The curricula used will include Partners in Prevention and the American Red Cross Basic Fundamentals. One collaborations will use BART curriculum for African American youth in summer programs 5 collaborations will conduct GLIs using multi-sessions conducted: • at AOD treatment sites; • with parents trained in sexuality education and communication; • with female youth trained to conduct high-risk youth groups; • with female youth trained in the Prudential "Youth Leadership Institute" curriculum plus HIV/STD risk reduction and skills building activities; • with women in housing areas using the "Laundromat Lunch N-Learn Program" curriculum; • using "Get Educated! Get Motivated!" curriculum; and • using "Get Real About AIDS!" curriculum. 1 collaboration will provide the "Be Proud! Be Responsible!" curriculum. 1 collaboration will provide the "BART" curriculum.	

Recommendations in the Plan	Interventions Proposed in the CDC Funding Application	
	…that match a recommendation in the plan	**…that do not match a recommendation in the plan**
Other Recommended Interventions: Community Based Counseling &Testing	2 collaborations will offer CBC&T 3 Collaborations will provide CBC&T to women in crisis centers, homeless shelters, or other community sites.	1 collaboration will provide outreach by peer educators and business leaders in community settings. Conduct community wide events in every health district/collaboration region.
Target Population #3: White Men Who Have Sex with Men (MSM), Ages 15-44		
Priority Interventions: Group Level Interventions: Provide peer led or peer involved group level, multi-session education/ counseling in accessible community settings.	2 Collaborations will provide multi-sessions using Peer Education Programs and/or the Partners in Prevention program at various community locations 2 collaborations will provide GLIs with WMSM.	1 Collaboration will provide OraSure testing at various community sites (CBC&T) 1 collaboration will conduct outreach by peers to WMSM by dissemination of prevention information and supplies in MSM-identified bars.
Community Level Interventions: Provide community level interventions involving popular opinion leaders and/or peer educators		1 collaboration will provide an HC/PI intervention with a billboard campaign. Messages will be directed to MSM.
Other Recommendations: Individual Level Interventions: Provide individual counseling services focused on healthy sexual practices as well as focusing on other psychosocial needs	1 collaboration will offer individual level counseling by the lead agency staff.	1 collaboration will offer CBC&T to WMSM
Target Population # 4: African American Male Injecting Drug User (IDU), Ages 20 - 44		
Priority Interventions: Individual Level Interventions: Provide individual level education in community settings.	**Priority Interventions:** Collaboration will provide individual sessions at detox centers to assist clients to identify risks and in developing a RR plan. 1 collaboration will provide ILI to increase prevention skills of clients in AOD treatment sites and homeless centers.	
Group Level Interventions: Provide peer led or peer involved group level, multi-session education/ counseling in accessible community settings.	2 Collaborations will provide multi-session program to clients in DAODAS and other treatment centers 2 collaboration will provide multi-session skills building GLI with AAMIDU in community settings, including treatment centers.	

Recommendations in the Plan	Interventions Proposed in the CDC Funding Application	
	…that match a recommendation in the plan	**…that do not match a recommendation in the plan**
Outreach: Provide peer or near-peer led street and community outreach.	2 Collaborations will provide outreach activities such as distributions of intervention kits 1 collaboration will conduct street outreach using peers to distribute needle-cleaning kits in shooting galleries.	
Other Recommendation: Community Based Counseling &Testing	1 collaboration will provide CBC&T to AAMIDU at homeless centers and methadone treatment centers.	
Target Population #5: African American Women Injecting Drug Users, Ages 20-44		
Priority Interventions: Individual Level Interventions: Provide individual level counseling in community and clinic settings.	Collaboration will provide individual sessions at detox centers to assist clients to identify risks and in developing a RR plan. 1 collaboration will provide individual counseling focusing on prevention skills building in homeless and AOD treatment centers.	
Group Level Interventions: Provide group level, multi-session education/counseling in accessible community settings.	2 Collaborations will provide mult-sessions RR/skills building program to clients in DAODAS and other community locations. Linking with DAODAS, 2 collaborations will conduct group education sessions involving peers.	
Outreach: Provide peer and non-peer street and community outreach.	1 collaborations will provide peer or non-peer delivered outreach education and distribution of intervention "kits" to IDUs.	
Other Recommendations: Community Based Counseling &Testing	Community-delivered counseling and testing using OraSure will be provided by 1 collaboration/CBO.	
Target Population #6: White Male Injecting Drug Users, Ages 20 -44		
Priority Interventions: Group Level Interventions: Provide small group, multi-session education in institutional settings (drug abuse treatment center, prison or shelter)	3 Collaborations will provide multi-sessions including RR and skills building to clients in DAODAS, other treatment and/or detention centers Linking with DAODAS, 2 collaborations will conduct group education sessions in drug treatment centers, prisons or homeless centers.	Collaboration will provide individual sessions at detox centers to assist clients to identify risks and in developing a RR plan. 1 collaboration will provide individual counseling to WMIDUs to build prevention skills of clients in homeless centers and AOD treatment centers.

Recommendations in the Plan	Interventions Proposed in the CDC Funding Application	
	…that match a recommendation in the plan	**…that do not match a recommendation in the plan**
Outreach: Provide street or community outreach	1 collaboration will provide peer or non-peer delivered outreach and distribution of IDU intervention "kits".	
Other Recommendations: Community Based Counseling &Testing		
(Unranked) African American Men who have Sex with Women (Ages 15-44)		
Group Level Interventions: Provide group level, multi-session education/counseling in accessible community settings.	3 Collaborations will provide sessions focusing on the increase of correct and consistent use of condoms, and other barrier protection, as well as knowledge of HIV transmission 3 Collaborations will provide sessions using BART and/or Rites of Passage curriculum for African American youth in summer and after school programs 3 collaborations will provide GLIs using:"BART", "Get Real About AIDS", "Get Educated! Get Motivated!", "Be Proud! Be Responsible", and the "Prudential Youth Leadership Institute" curricula.	Individual level counseling will be provided by 2 collaborations. 1 collaboration will conduct capacity building activities using the "Sheer Devotion" curriculum to train staff of beauty salons, barber shops and other businesses.
Community-Level Interventions: Culturally appropriate prevention marketing in settings targeting AA men, e.g. churches, youth rallies, basketball events.		1 Collaboration will provide one to one condom distribution and HIV prevention messages in areas where high risk people hangout (Outreach) 1 collaboration will conduct outreach activities using peer educators in African American business and other community-based settings.
Other Recommendations: Community Based Counseling &Testing	Community-delivered counseling and testing using OraSure will be provided by 3 collaborations/CBOs.	Collaboration will participate in the Annual Brothers United Change Black Male Conference (HC/PI) 1 collaboration will conduct HC/PI for AA MSW. 6 Collaborations will provide single session presentations on HIV transmission at various community settings (HC/PI)

b. Differences Between Recommendations In The Plan And The CDC Funding Application.

The STD/HIV Division used the priority recommendations in the 2002-2004 Plan to guide the selection of interventions and target populations of local prevention collaboration member organizations as well as local health departments -- the two systems that receive HIV prevention

funds. The 2003 implementation of interventions stated in the preceding table will be conducted by those collaborations and local health departments that currently have the capacity (e.g. trained staff, expertise, access to target populations, etc.). Collaboration contracts for 2003 will be amended to include the specific interventions and target populations to be provided with 2003 funds. Other collaborations that are more recently formed (in 2000) or that have less resources, may need additional training and technical assistance during 2003 to implement certain interventions, such as group level multi-session peer led interventions with African American Men who have Sex with Men (MSM).

The three new contracts established in December 2001 with supplemental funds will be continued and focus on the priorities stated to reach African American MSM and HIV infected persons (included as a subpopulation in each of the above populations).

Additionally, it is not expected that all collaborations will implement all interventions for every target group. Collaborations will be developing their respective local implementation plans during the fall of 2003 and will use the CPG priorities in determining strategies based on their local needs and epidemiologic profile. While injecting drug users were identified as priority populations, not all geographic regions of the state have high proportions of injecting drug use. Crack cocaine is a drug of particular concern in the state's HIV prevention efforts. Reports from outreach workers and DIS staff indicate that among African Americans at increased HIV risk, crack cocaine is playing an increasing role. This includes behaviors such as the exchange of sex for drugs as well as high-risk sexual activities while under the influence of crack. Also, the CPG Priority Setting Workgroup considered crack use as a surrogate marker, especially related to other STDs. Therefore, STD/HIV staff in local health departments and collaborations in areas of highest IDU prevalence and/or crack cocaine use will conduct interventions specific to these concerns.

The target populations addressed in South Carolina's funding application are consistent with the priority populations in the Plan for CY 2002-2004. The proposed interventions are also essentially consistent with the plan. These interventions are stated in the target population profile/descriptions located on pages 3.3 –3.17 in Chapter 3 of the Plan. The interventions include the priority interventions selected during CPG's 2000 priority setting process and other recommended interventions based on the Phase I needs assessment process conducted in 2001. In the previous table these are noted as "Other Recommendations".

The one intervention type that will be funded in a lesser amount is HC/PI (special events and public information activities such as World AIDS Day events, others). These interventions will be supported because they facilitate access to target populations, help to establish credibility with target populations, and help to gain local community support and awareness of the need for HIV prevention services. Staff will work with local providers to ensure that HC/PI activities are linked to the provision of individual and group level interventions.

c. Goals, Objectives And Activities For Target Populations

The following objectives for each target populations are the same as the Health Education/Risk Reduction objectives on pages 7.4 – 7.6 in Chapter 7 of the 2002 – 2004 Plan.

Primary Population #1: African American Men who have Sex with Men, ages 15-44

Goal:
Reduce the number of new HIV cases among adolescent and adult men who have sex with men by at least 25% (Linked to Healthy People 2010 National Objective 13.2)

Objectives:
By 2004, increase by 25% the proportion of African American Men Who Have Sex With Men (MSM) Ages 15-44 who report risk reduction practices through outcome monitoring.

By 2003, increase by 50% the proportion of African American Men Who Have Sex With Men (MSM) Ages 15-44 who participate in peer or non-peer led small group, multi-session skills building education for the adoption and maintenance of HIV risk reduction behaviors. At least two will occur in correctional settings.

Strategies:
1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

   By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

Primary Population #2: African American Women who have Sex with Men, ages 15-44

Goal:
Reduce new HIV/AIDS rates in heterosexual African American Women to 19.5 per 100,000 population. (Linked to Healthy People 2010 National Objective 13.1)

Objectives:
By 2004, increase by 25% the proportion of African American Women Who Have Sex With Men (WSM) Ages 15-44 who report risk reduction practices through outcome monitoring.

By 2003, increase by 50% the proportion of African American Women Who Have Sex With Men (WSM) Ages 15-44 who participate in individual level multi-session skills building education for the adoption and maintenance of HIV risk reduction behaviors, provided to one person at a time.

By 2003, increase by 50% the proportion African American Women Who Have Sex With Men (WSM) Ages 15-44 who participate in peer-led and non-peer led group-level multi-session education interventions in housing centers and other community settings.

Strategies:
1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

3. By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

Primary Population #3: White Men who have Sex with Men, ages 15-44

Goal:
Reduce the number of new HIV cases among adolescent and adult men who sex with men by at 25%. (Linked to Healthy People 2010 National Objective 13.2)

Objectives:
By 2004, increase by 25% the proportion of White Men Who Have Sex With Men (MSM) Ages 15-44 who report risk reduction practices through outcome monitoring.

By 2003, increase by 50% the proportion of White Men Who Have Sex With Men (MSM) Ages 15-44 who participate in group level, multi-session education interventions program to reduce HIV risks.

Strategies:
1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

3. By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

Primary Population #4: African American Male Injecting Drug Users, ages 20-44

Goal:
Reduce the number new HIV/AIDS cases among this population by at least 25%. (Linked to Healthy People 2010 National Objective 13.3)

Objectives:
By 2004, increase by 25% the proportion of African American Male Injecting Drug Users (IDU) Ages 20-44 who report risk reduction practices through outcome.

By 2003, increase by 50% the proportion of African American Male Injecting Drug Users (IDU) Ages 20-44 who are involved in skills-based group education sessions conducted in drug abuse treatment centers, prison, or shelters.

By 2003, increase by 50% the proportion of African American Male Injecting Drug Users (IDU) Ages 20-44 who participate in peer or non-peer delivered outreach education and distribution of intervention "kits" to reduce HIV risks.

Strategies:
1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

3. By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

Primary Population #5: African American Female Injecting Drug Users, ages 20-44

Goal:

Reduce the number new HIV/AIDS cases among this population by at least 25%. (Linked to Healthy People 2010 National Objective 13.3)

Objectives:

By 2004, increase by 25% the proportion of African American Female Injecting Drug Users (IDU) Ages 20-44 who report risk reduction practices through outcome monitoring.

By 2003, increase by 50% the proportion of African American Female Injecting Drug Users (IDU) Ages 20-44 who participate in peer or non-peer delivered outreach education and distribution of intervention "kits" to reduce HIV risks.

By 2003, increase by 50% the proportion of African American Female Injecting Drug Users (IDU) Ages 20-44 who are involved in skills-based group education sessions conducted in drug abuse treatment centers, prison, or shelters.

Strategies:

1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

3. By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

Primary Population #6: White Male Injecting Drug Users, ages 20-44

Goal:

Reduce the number new HIV/AIDS cases among this population by at least 25%. (Linked to Healthy People 2010 National Objective 13.3)

Objectives:

By 2004, increase by 25% the proportion of White Male Injecting Drug Users (IDU) Ages 20-44 who report risk reduction practices through outcome.

By 2003, increase by 50% the proportion of White Male Injecting Drug Users (IDU) Ages 20-44 who participate in peer or non-peer delivered outreach education and distribution of intervention "kits" to reduce HIV risks.

By 2003, increase by 50% the proportion of White Male Injecting Drug Users (IDU) Ages 20-44 who are involved in skills-based group education sessions conducted in drug abuse treatment centers, prison, or shelters. No baseline data available.

Strategies:

1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

3. By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

Primary Population (unranked): African American Men who have Sex with Women, ages 15-44

Goal:

Reduce new HIV/AIDS rates in heterosexual African American Men by at least 25%. (Linked to Healthy People 2010 National objective 13.1)

Objectives:

By 2004, increase by 25% the proportion of African American Men who have Sex with Women (MSW) Ages 15-44 who report risk reduction practices through outcome monitoring.

By 2003, increase by 50% the proportion African American Men who have Sex with Women (MSW) Ages 15-44 who participate in peer-led and non-peer led group-level multi-session education interventions in housing centers and other community settings.

By 2003, increase by 50% the proportion of African American Men Who Have Sex With Women (MSW) Ages 15-44 who participate in culturally appropriate prevention marketing in various settings.

By 2003, increase by 50% the proportion of African American Men Who Have Sex With Women (MSW) Ages 15-44 who participate in community based counseling and testing.

Strategies:

1. By January 2003, local implementation plans from the 11 Collaborations and 13 health districts be finalized and amended if needed to ensure priority populations and interventions are being focused on according to recommendations in the 2002 – 2004 Plan.

2. By April 2003, each funded contractor will submit data on a quarterly basis to DHEC STD/HIV Division to meet CDC requirements set forth in the Evaluation Guidance.

3. By December 2003, STD/HIV Division staff will conduct site visits to observe quality of interventions and review quarterly data to determine level of implementation of each contract. Quarterly data reports will also include information on progress toward objectives and problems with meeting objectives.

d. Other 2003 Programmatic Goals And Objectives

This section describes other programmatic efforts that are funded. Objectives for each programmatic effort are essentially the same as objectives in Chapter 7 of the 2002 – 2004 Plan. CTRPN are required activities and the CPG indicated that these should be conducted as they have been although there should be emphasis on expanding community based opportunities for testing. New or changed objectives/activities are noted below.

1) Counseling, Testing, Referral, and Partner Notification

Goal: To increase the proportion of HIV infected persons who have knowledge of their serostatus, particularly among priority target populations. [Ongoing Goal]

Objective 1: By December 2003, reduce new HIV infections, especially among African American adults/adolescents at risk, by increasing access to community delivered prevention services in 95% of counties with HIV prevalence rates among African Americans >500.0. [Revised, updated Objective]

Objective 2: By December 2003, continue monitoring of HIV prevention counseling standards, outcome measures for clients, and quality assurance indicators and procedures for monitoring by supervisors or peers. [Revised, updated Objective]

Objective 3: By December 2003, local health departments and collaborations providing HIV counseling and testing will provide test results counseling to at least 95% of persons testing positive and 75% of persons testing negative who indicate high risk behaviors. [New Objective]

Strategies/Activities:
Counseling and testing (using OraSure) services conducted by collaborations are primarily in counties where the prevalence rate among African Americans is 500.0 or greater. The focus of these expanded opportunities for learning HIV serostatus will be on reaching the priority target populations for 2003 as described in previous sections.

Staff monitor counseling and testing program data to assess level of targeted testing, particularly services provided routinely in STD, Family Planning and Prenatal clinics. The target populations ultimately to be served are African Americans at risk, substance users, HIV infected persons, men who have sex with men as evidenced by current populations utilizing counseling and testing services, and those at risk indicated by HIV/AIDS surveillance data. Feedback will be shared with local health department staff to decrease the level of testing to clients who are not at increased risk.

During 2003, the state office will provide at least five prevention counseling training sessions for local health department staff providing STD/HIV services, county alcohol and drug abuse commission staff, and selected community/collaboration alternate sites.

Guidelines and Standards for Quality Prevention Services have been developed and are used by the lead prevention counseling consultant in the state office to monitor local health department and community organization staff. Site visits are conducted which includes direct observation of staff; feed back is provided incorporating any needed technical assistance.

Objective 3: By 2004, reduce HIV related morbidity/mortality by increasing proportion of under-served/uninsured HIV infected people in South Carolina who are linked to appropriate care and treatment services from estimated 50% to 80%. [Revised, On-going Objective]

Objective 4: By December 2003, assure that 100% of the individuals with newly identified HIV

infection in publicly funded sites receive, either directly or through referral, access to appropriate primary ad secondary prevention services including CD4 testing, TB testing, and early intervention services. [Revised, On-going Objective]

Strategies/Activities:
All newly diagnosed persons with HIV infection in counseling and testing sites are referred to existing care services. Depending on insurance status or personal situations, clients are referred either to private providers or the Ryan White Care Consortia. In order to facilitate referrals, county health department counseling and testing sites offer CD4 and viral load tests. The goal is for referred clients to seek care and treatment services according to Public Health Service guidelines. Barriers for many clients newly diagnosed actually completing referrals reported by counselors include denial of illness, not feeling "sick", and fear of confidentiality loss. Many clients state they will not enter care until their CD4 count is below 500.

Current data on the outcome of referrals from health departments to care providers are not complete—it is difficult for counselors to follow-up and receive information from providers and clients on whether appointments were kept. The Ryan White care consortia have developed a statewide client database which will be used to assess and evaluate required outcome indicators. Prevention staff will explore possibility of using this system to track outcome of referrals of HIV infected clients from counseling and testing sites to consortia. Further, some of the barriers noted above may be reduced by the proposed expanded counseling and testing activities described above since many of the collaboration organizations that would provide this service are also lead or key agencies of local care consortia. In otherwords, the HIV counseling and testing staff may also be a case manager for care services, or the organization (i.e. site) would have case management staff directly available to link HIV positive clients for medical evaluation.

Objective 5: By December 2003, partner notification services will be provided to at least 60% of all newly reported persons with HIV disease, and 95% of those screened for "eligibility" for follow-up by local health department staff. [Ongoing Objective]

Strategies/Activities:
Continue to provide partner referral services. Staff will provide any appropriate training to reflect new CDC guidelines on partner counseling. Staff will monitor partner referral data to evaluate effectiveness, client acceptance, staff capacity to provide services (particularly in areas of high case loads).

2) Health Communication/Public Information:

Goal: Provide a variety of public information activities to general audiences to dispel myths and address barriers to effective prevention programs, and to persons at increased risk for HIV and STDs to support efforts for personal risk reduction and assist in locating available prevention and care resources. [On-going Goal]

Objective 1. By February 2003, purchase or develop culturally appropriate materials and public information items for priority populations based on input from local providers regarding specific gaps or needs. [Revised]

Objective 2. By March 2003, collaborate with various health districts, community-based organizations and agencies to develop targeted, culturally specific radio messages and other media awareness opportunities focusing on HIV and STD awareness and promote knowledge of HIV serostatus among African Americans and Latinos. [Revised]

Objective 3. By December 2003, provide media assistance to local providers by way of radio interviews, live remote and PSAs. [Revised, Ongoing]

Objective 4. By December 2003, assist local providers in conducting at least one public information event. [Revised, Ongoing]

Strategies/Activities:
Obtain early information/packets about World AIDS Day and/or National HIV Testing Day. Assure that these information packets are distributed to local collaborations and health department staff in a timely fashion. Assist as needed in the development of other media materials/news releases.

Objective 5. By December 2003, coordinate with the AIDS/STD Hotline to disseminate testing and special event information to callers who heard messages via the radio spots (Ongoing)

Objective 6. By December 2003, provide at least 4 quarterly training sessions for the hotline staff to provide up-to -date information to consumers on HIV and other STDs, anonymous risk reduction education, and referrals for counseling and testing, care and supportive services through the toll free South Carolina AIDS/STD Hotline. [Ongoing]

Strategies/Activities:
Provide educational experiences in the form of skills-focused meetings, training workshops and professional conferences for hotline staff.

Objective 7. By January, 2003, market and provide bilingual STD/HIV information and referral services to Spanish-speaking callers on the South Carolina AIDS/STD Hotline. [New]

Strategies/Activities:
Maintain at least one Spanish-speaking staff person on the South Carolina AIDS/STD Hotline. Develop and distribute culturally specific and relevant promotional materials for Latino/Latina consumers.

Objective 8. By December, 2003, maintain a high quality and user-friendly electronic medium where the public and professional consumers may access STD/HIV information, statistics, HIV prevention community planning, HIV Prevention Collaborations. [New]

Strategies/Activities:
Continue to monitor web pages and update and improve based on feedback from the CPG, district public health staff, and Collaboration members. Develop and administer a survey of user capabilities and knowledge of use. Conduct at least one training experience for members of the CPG and collaborations to improve computer skills.

Objective 9. By June 2003, revise and distribute the Statewide HIV/AIDS Resource and Information Network Guide (SHARING) containing key resources for prevention, treatment and support services. [New]

Strategies/Activities:
Solicit via phone, written and electronic surveys current referral information from key providers in the state. Revise SHARING in a streamlined version. Distribute to agencies and to minority and other CBOs throughout the state.

Objective 10. By December 2003, continue to utilize the federal materials process with all HIV materials developed or purchased with CDC HIV prevention funding [New]

Strategies/Activities:
Hire an hourly part time Federal Materials Review Coordinator to organize and facilitate the federal materials review process. Assist in the development of a federal materials review protocol and web page. Continue to recruit new members and to promote the review process. Record all materials submitted to the committee as well as the item's approval status.

3) Capacity Building

Goal 1: Provide financial and technical assistance to strengthen both the public health infrastructure and that of non-governmental organizations to deliver effective HIV prevention interventions. [On-going Goal]

Objective 1: By December 2003, conduct at least 8 training events on behavioral interventions, effective programs, and/or program development to address training needs of local prevention staff/organizations. [Revised, Ongoing]

Objective 2: By December 2003, conduct at least 5 basic HIV prevention counseling training courses and 5 HIV Basic Facts courses for local prevention staff. [Revised, Ongoing]

Objective 3: By October 2003, assist in planning the annual HIV/STD Conference. [Ongoing Objective]

Objective 4: By January 2003, conduct the SC HIV Prevention Community Planning "Leadership Summit" conference for community planning group members, local prevention collaborations, and public health district staff to increase knowledge and skills in prevention planning and evaluation. [Revised, Ongoing]

Strategies/Activities:
Local prevention providers have identified the need to have ongoing training in developing and conducting theory-based and effective HIV prevention interventions. Training sessions will be offered to local collaboration member organizations, local health department and alcohol and drug abuse agency staff. Future training plans include collaboration with Jackson State University to offer Community Mobilization. There will also be collaboration with the Dallas STD/HIV Behavioral Intervention Training Unit to offer a series of courses: Bridging Theory and Practice: Applying Behavioral Theory to STD/HIV Prevention, Community Identification: Focusing on Adolescents, Community Identification: Learning About the Community First, Community-level HIV/STD Behavioral Interventions, and Sexual Communication: Interventions for Individual Behavior Change. In addition, plans are underway to collaborate with the Florida STD/HIV Training Unit of the Florida Health Dept. to offer STD/HIV clinical updates.

There is an ongoing need for basic HIV information and South Carolina program, policy information. In particular this is recommended as a prerequisite for any staff providing prevention counseling and testing services. In the past, DHEC has contracted with the American Red Cross to provide HIV/AIDS Starter Facts and HIV/AIDS Facts Practice courses. Due to budget cuts impacting the Red Cross, DHEC may need to examine other options for providing this training, such as contracting with specific trainers, utilizing current staff, etc.

An annual statewide HIV/STD conference is sponsored by several agencies (University of South Carolina School of Public Health, SC AIDS Training Network, DHEC, Department of Alcohol and other Drug Abuse Services, and several community-based organizations). The conference agenda includes both HIV/STD prevention and care topics. Over 500 participants from various organizations attend. DHEC staff will continue to serve on the planning committee and provide support for local staff to attend.

There is a need to increase communication among CPG, DHEC and local prevention providers to elicit better input from all entities and to build planning skills at both local and state levels. An HIV prevention leadership summit, hosted by the CPG, will be conducted in January 2003 for this purpose.

As revealed in various technical assistance needs assessment activities, there is a need to continue to provide resources to minority and other community-based organizations to implement HE/RR activities through collaboration with the Office of Minority Health, NMAC technical assistance, and other partners.

Goal 2: To provide resources to minority and other community-based organizations to implement HE/RR activities. [Updated, revised]

Objective 1: By December 2003, continue to provide resources to minority and other community-based organizations to implement HE/RR activities through collaboration with the Office of Minority Health, NMAC technical assistance, and other partners.

Strategies/Activities:
Provide linkages for OMH staff conducting HIV capacity-building demonstration grant. Participate on the Project Advisory Committee. Participate in budget planning processes and plan for providing technical assistance to identified Minority Community Based Organizations not traditionally involved with HIV prevention activities as a sole agency mission.

4) Quality Assurance and Training

Goal: Develop and implement quality assurance procedures and training for staff providing prevention services including contracted organizations.

Objective 1: By 2003, provide on-going technical assistance and contract modifications/monitoring of 11 collaborations to increase number of interventions available to priority populations as reflected in the statewide prevention plan. [Revised, Ongoing]

Strategies/Activities:
Amend annual contracts to include contract objectives addressing required interventions and target populations and performance for each. Annually review accountability reports for each contractor and determine if contract will be continued, what strengths /improvements are noted, etc. Conduct sites visits for review of documentation for invoicing as well as programmatic record review. In conjunction with Internal Audits staff, determine which contractors may meet OMB 1-33 Audit requirement and work to ensure contractor has scheduled to complete

Objective 2: By 2003, provide on-going quality assurance monitoring of prevention counseling staff. [Ongoing]

Strategies/Activities:
Staff will obtain and review required quarterly narrative reports; conduct visits to review program plans and determine progress; complete site visit reports, and provide follow-up with any technical assistance determined.

Objective 3: By 2003, DHEC staff will implement quality assurance assessments utilizing the HE/RR Intervention Quality Assurance Tool to monitor HIV prevention programs/interventions at least once for 11 collaborations and 13 health districts.[Revised, Ongoing]

Strategies/Activities:
Collaboration consultants will work together in conducting QA assessments utilizing the comprehensive quality assurance tool that will be used to monitor and evaluate the HE/RR interventions being conducted by the collaborations and health districts. Two consultants will divide the contractors and districts and develop schedule for conducting at least one assessment during 2003.

2. 2003 PREVENTION FOR HIV-INFECTED PERSONS PROJECT

South Carolina does not receive funding for this project.

3. PERINATAL SUPPLEMENTAL AWARD

a. Proposed 2003 Services

There are few changes or additions to the program activities for 2003 from those proposed in the year 2002 plan. Revisions are indicated below in the objectives/activities section.

From the cascade of seven services stated in the supplemental announcement, South Carolina is primarily addressing "other HIV-related prevention and care services during the perinatal period". The specific intervention is prevention case management for HIV infected women during the perinatal period in the three counties of highest HIV perinatally-acquired infection (Richland, Sumter, and Charleston). Prevention case management (PCM) services will address many of the other steps (e.g. prenatal care, zidovudine use, avoidance of breast feeding) as appropriate for each woman.

Other steps in the cascade to be addressed through coordination and linkages with existing systems, provider training and hospital policy development are education about the importance of HIV testing; voluntary HIV testing; for those who are positive, post-test counseling and zidovudine to reduce perinatal transmission, antiretrovirals for the benefit of the women's own health.

The target population that prevention case management services address are pregnant HIV infected women in Richland, Sumter, and Charleston counties. PCM staff will focus on women who receive inadequate prenatal care or no prenatal care and on HIV infected women with complex psychosocial issues who may not adhere to recommended antepartum or postpartum therapy and/or care plans.

The provider target population will include hospital-based staff providing labor and delivery services. Based on the responses to the needs assessment conducted during 2000 regarding current policies around routine, voluntary rapid testing of women during labor and delivery, follow-up will be conducted. Hospitals that have no policies/procedures or those that do not meet PHS guidelines, will receive follow-up assistance to plan and implement such policies. Representatives of these providers participate on the state's four regional perinatal boards administered by state MCH program staff. The Boards are comprised of public and private providers of perinatal care. Input on planning assessment and policy development and implementation will be obtained by the Project Director linking with members of the regional boards.

Additionally, prenatal care providers will be targeted for education, training and technical assistance to increase the number offering HIV testing to all pregnant women/exposed infants, appropriate treatment/care services for pregnant women and referrals to prevention services for pregnant women who test negative but may be at high risk for HIV infection. A statewide Obstetrics Task Force, formed under coordination of DHEC's MCH program, will be used to

obtain input on training needs, service needs, barriers, etc.

b. Goals

Impact Goal: No more than five cases of perinatal HIV transmission will occur in each birth cohort year by 2003. [Ongoing]

Outcome Goals:

1. By 2003, 95% of pregnant women in South Carolina, especially those at high risk for HIV, will receive voluntary HIV testing, at the time they access the medical care system. [Ongoing]

2. By 2003, 82% of pregnant women infected with or at high risk for HIV infection will receive adequate prenatal care (as defined by MCH program). [Ongoing]

3. By 2003, 95% of HIV infected women and their infants will have access to appropriate prevention interventions to reduce perinatal HIV transmission and will have access to appropriate treatment services. [Ongoing]

c. Intervention Objectives/Activities

The following process objectives/activities are proposed in order to accomplish the long term goals. The Goal that the objective relates to is indicated after each objective.

1.By December 30, 2003, staff will conduct educational visits and follow-up technical assistance for institutions providing labor and delivery services and prenatal care providers in the counties of highest incidence of HIV exposed infants. Education will focus on promoting prenatal and labor and delivery screening practices and administration of appropriate antiretroviral treatment. (Goals 1, 3) [Revised, Ongoing Objective]

2.By December 30, 2003, Pediatric AIDS Project Coordinator/staff will continue collaboration with Obstetrics Task Force and obtain input on issues, concerns, barriers, solutions regarding offering of HIV testing to all pregnant women and HIV-exposed infants. (Goal 1) [Ongoing Objective]

3.By December 30, 2003, Pediatric AIDS Project Coordinator/staff will continue communication and collaboration with existing MCH committees, organizations focusing on increasing rates of adequate prenatal care among high risk women to integrate HIV perinatal prevention messages/activities as appropriate. (Goal 2) [Ongoing Objective]

4.By December 30, 2003, Pediatric AIDS Project Coordinator/staff will continue collaboration with HIV Prevention Collaborations statewide and the Women's Resource Center in Columbia to design feasible education efforts based on consumer input to inform high risk women in these project service areas of the importance of HIV testing during pregnancy. (Goal 1) [Revised, On-going Objective]

5. By December 30, 2003, the SC AIDS Training Network in collaboration with project planning/advisory team will complete in-service training, and education to at least 75% of

prenatal care providers, especially those in areas of the state identified by follow-up analysis of perinatal HIV cases where women did not receive HIV testing. (Goals 1, 3) [Ongoing Objective]

6. By December 30, 2002, 95% of referred HIV infected pregnant women in the Richland/Sumter/Charleston area will receive prevention case management services to facilitate access to other services and address prevention behavior change plans. (Goals 1,2,3) [Ongoing Objective]

Specific Activities/Services

a. HIV surveillance program staff currently receive CDC funds to collect/review surveillance data to identify successes and missed opportunities for perinatal prevention activities. The HIV prevention program director and the HIV surveillance program director work closely to plan and implement these surveillance efforts. Additionally, there has been close collaboration to analyze and present data to MCH program staff, SC Medical Association MICH Committee, DHEC Commissioner's statewide Pediatric Advisory Committee, Ryan White Title II and IV providers and others to provide feedback and information on the effectiveness of perinatal HIV efforts and to discuss strategies for addressing systems barriers, specific populations to reach, etc. These efforts will continue during the project period for all perinatal cases statewide.

b. There are 11 HIV prevention collaborations providing community level interventions targeting populations at risk identified by the statewide HIV prevention community planning group. The HIV prevention collaborations also cover the areas of the state with the highest prevalence of HIV among women. A key target population of collaborations is African American women at risk (which would include pregnant women at risk for HIV). The Pediatric AIDS Project Coordinator (funded by Ryan White Title IV) and staff will continue linkages/coordination with these existing projects to integrate practical, feasible education efforts to better inform pregnant women of the importance of HIV testing and available treatments to prevent perinatal transmission.

c. Maternal and Child Health Services at DHEC includes a perinatal regionalization program. This program has linkages with the licensed perinatal hospitals and providers in the state. There are Obstetrical and Neonatal Outreach Educators located in six regional perinatal centers who have relationships with hospitals. STD/HIV Division, MCH, and Bureau of Disease Control will provide various educational opportunities for providers and hospital labor and delivery staff particularly in the Midlands, Wateree, Pee Dee and Waccamaw areas. These area have highest rates of HIV among childbearing women.

d. Education and outreach activities to pregnant women, especially those at high risk for HIV (e.g. low-income, substance users) to increase those who obtain prenatal care are currently provided by MCH program staff in local health departments, WIC programs, substance use programs, Healthy Start, March of Dimes and others. All HIV prevention counseling and testing staff, community collaborations conducting HIV prevention interventions to pregnant women, and Ryan White Care Act Title II and IV staff currently provide education to known HIV infected women who are pregnant and provide referrals to prenatal care providers. These services are available to women statewide.

e. The South Carolina AIDS Training Network (SCATN) collaborates with agencies and organizations to conduct HIV-related training for clinicians in medical and health settings. Under a Memorandum of Agreement/Contract with the SC Department of Health and Environmental Control (DHEC), the SCATN will take a three-pronged approach to increase the number of providers who offer (1) HIV testing to all pregnant patients and HIV-exposed infants, (2) appropriate treatment and care services to HIV-infected pregnant women, and (3) appropriate prevention services for pregnant women who test negative but may be at high risk for HIV infection. This three-pronged approach includes the following:

- coordination of training for local obstetricians/gynecologists identified by the SC Perinatal HIV Transmission Prevention Project;
- publishing on a website a clinicians' manual on the SC Perinatal HIV Transmission Prevention Project, an overview of project services including prevention case management, and appropriate counseling, testing and care for pregnant women with HIV or pregnant women at high risk for HIV infection in accordance with the latest US Public Health Service guidelines.

Evaluation efforts for perinatal prevention are the same as detailed in the 2002 application.

4. PROGRAM EVALUATION

a. South Carolina HIV Prevention Evaluation Plan

This plan describes the STD/HIV Division's evaluation plan for each type of required evaluation that will be conducted and describes the state health department's needs for evaluation-related technical assistance.

Evaluation Goals:

1. To evaluate the HIV prevention community planning process.
2. To design and evaluate intervention plans.
3. To monitor and evaluate the implementation of HIV prevention programs.
4. To evaluate linkages with the comprehensive HIV prevention plan and the application for funding.
5. To monitor outcomes of HE/RR individual and group level interventions.
6. To evaluate outcomes and monitor the impact of HIV prevention programs.

Strategies and Timelines for Meeting Evaluation Guidance Requirements

Below is a table listing each major evaluation goals with a description of activities and the timeline for accomplishing the activities in 2003.

Evaluate the HIV Prevention Community Planning Process	
Activities:	Timeline
1. Complete Membership Grid	February 2003
2. Conduct survey of CPG members about the community planning process using tool in Volume 2: Guidance: Evaluating CDC-Funded Health Department HIV Prevention Program	November 2003
Design and Evaluate Intervention Plans	
Activities:	
1) Continue training and provide technical assistance on the definitions for target populations, intervention types, and the interventions forms.	Ongoing
2) Collaborations and districts will submit the intervention forms for review.	August 2003
3) Aggregate information on intervention forms and send to CDC with funding application	September 2003
4) Evaluate intervention plans for core set of data elements including approximate number and characteristics of people to be reached, categorized by type of intervention, sufficiency of evidence basis, and sufficiency of service plan for implementation.	September 2003
5) Provide feedback, training, and assistance during Fall planning cycle to improve quality of intervention plans.	October – December 2003
Monitoring and Evaluating Implementation of HIV Prevention Programs	
Activities:	
1) Data entry by DHEC staff and Collaborations using CODES. Data collected will include routine documentation of characteristics of the people served, the services that were provided, and resources used to provide those services.	January 2003
2) Compare and contrast intervention plans with intervention data collected.	Quarterly
3) Identify areas for improvement.	On-going 2003
4) Provide on-going feedback and technical assistance to Collaborations and district staff.	On-going 2003
5) Provide information to the CPG for decision making.	As requested.
6) Report evaluation data in 2004 application.	September 2003
Evaluating Linkages Between Comprehensive HIV Prevention Plan, CDC Funding Application, and Resource Allocation	

Activities:	
1) Gather additional information on interventions for target population.	Ongoing 2003
2) Inventory current interventions being conducted.	February 2003
3) Revise HIV Resources Inventory	May 2003
4) Revisit prioritization of interventions.	June 2003
5) Create table that lists recommendation for interventions in the Plan and a list of activities that funds have been used to support.	August 2003
6) Evaluate and assess the linkages.	August 2003
7) CPG make recommendation for improvements/changes.	August 2003
8) DHEC write the funding application for 2003.	August 2003
9) CPG reviews and concurs with funding application. Recommends changes/improvements in application.	August 2003
10) Funding application submitted to CDC.	September 2003
Evaluating Outcome Monitoring of at least five HE/RR Individual or Group Level Interventions	
Activities:	
1) Reconvene stakeholder group.	November 2002
2) Select at least 5 providers conducting Individual or Group Level Interventions to implement outcome monitoring per CDC guidance.	December 2002
3) Determine behavioral and other data to be collected	January 2003
4) Finalize intervention curricula, components, and methods.	February 2003
5) Finalize data collection instruments and process.	March 2003
6) Select 1 – 2 sites to pilot process; make adjustments as needed.	March 2003
7) Implement outcome monitoring process with providers.	May 2003
8) Conduct quarterly data analysis, provide feedback to provider.	August 2003
9) Analyze annual outcome monitoring data and write results.	September 2003
10) Disseminate data to providers, CPG, CDC and others.	April 2004

2. Plans for Data Collection, Analysis, Submission and Use

a) Process Monitoring/Process Evaluation

All contracted providers (HIV prevention collaborations) and local health department staff must conduct process evaluation. Several systems have been in place to monitor the implementation of programs in South Carolina. Below is a summary description by each program component.

(1). *Counseling, Testing, and Referral Services* demographic data are collected by utilizing the SC DHEC HIV Serology Request Form. Data on individuals tested in local health departments and contracted collaborations are keyed into a computer file at the Bureau of Laboratories and confidentially stored. The DHEC Laboratory conducts all HIV testing for the STD/HIV program. The STD/HIV program has developed an output report with the data required for the CDC counseling and testing reports. Data on pre-test and post-test counseling and referrals are maintained in clinic records and a Patient Automated Tracking System (PATS). Local data are transmitted to a state database from which counseling reports are performed.

(2). *Partner Counseling and Referral Services* information is collected utilizing the CDC Interview Record form. All forms are sent to the STD/HIV Division on a monthly basis and entered in an *Epi Info* database and the HIV/AIDS Reporting System (HARS) for data maintenance and reporting.

(3) *Health Education/Risk Reduction Services* are primarily provided by AIDS Health Educators (AHEDS) in the 13 public health districts and the 11 HIV Prevention Collaborations. Due to staff vacancies and software development technical delays, the web-based system called CODES (Collaboration and District Evaluation System) was not completed for reporting use in early 2002. It is expected to be complete and operational by the end of 2002. CODES will also be the mechanism for monitoring STD/HIV interventions at the local level. CODES captures information about the organization conducting interventions, target populations, intervention types, demographics (race/ethnicity, age, gender), materials used, and collaborating partners. DHEC will convene a workgroup of providers to develop clear definitions of interventions and target populations and to train prevention providers in using the system. CODES is a standardized system that generates reports (using Chrystal Reports) that will be used to report to CDC's ERAS (Evaluation Reporting and Analysis System). Reports can be used by prevention providers to evaluate and improve services at the local level. Local providers have been reporting data on paper forms during 2002.

(4). *Public Information* data are collected in two ways. The DHEC AIDS/STD Hotline staff utilize *EPI Info* to capture information from all callers who are responded to by a staff person. After-hours callers get a message that directs them to the CDC National AIDS Hotline, and advises them of the DHEC Hotline's hours of operation so that they can call back to get information and counseling and testing referrals. An analysis is made of the data collected from calls answered by a staff person. Data collected include demographics, risk information if provided, type of information requested, and referral source, e.g. telephone directory listing, radio PSA, etc.

Public information activities provided by local collaborations/district staff are reported through the CODES reporting system described above.

(5). *Capacity Building, training, and technical assistance* data is captured using logs and computer processing software (Word Perfect 6.0). A database is maintained that lists each training event, number of participants, organization/affiliation of participants. Pre/post training assessments used are maintained by the individual trainers.

b) Outcome Evaluation /Outcome Monitoring

South Carolina is required to conduct an outcome evaluation with a selected intervention or set of integrated interventions. CDC revised the guidance for states required to conduct outcome evaluation. CDC's revised evaluation guidelines allow states to conduct outcome monitoring for specific interventions as an alternative to the more rigorous outcome evaluation process. South Carolina will be conducting outcome monitoring with selected populations/prevention providers with the new evaluation staff capacity expected to be hired in October 2002.

Based on the recommendations for research in the 2002-2004 Prevention Plan, input from local

providers and desires of policy-makers and funders in South Carolina, DHEC will be developing an outcome monitoring process during the next two years to determine the statewide effectiveness of selected prevention programs. CDC evaluation funds as well as existing state and local staff will support this effort

DHEC and local Ryan White care providers have recently developed an outcome monitoring/evaluation plan to determine the impact of care services. This process utilized a committee of key stakeholders and followed the United Way Model process "Measuring Program Outcomes: A Practical Approach." Similar to the HIV care model, prevention outcome monitoring will emphasize development of a selected number of practical, feasible outcomes and indicators and selection of essential data systems to measure indicators. The outcome evaluation/monitoring committee will utilize the key research questions in the CPG Plan as a framework for selecting prevention outcomes.

In the short term, local prevention providers may begin implementing outcome monitoring as resources allow. To assist, DHEC will provide sample questionnaires, data collection tools to measure pre/post impact. Feedback from those providers who initiate outcome evaluation will be useful and important for the development of a statewide system as described above.

d) 2002 – 2003 Outcome Evaluation Plan

CDC-Defined Outcome Monitoring Proposed Evaluation Projects:

Intervention Type - Group Level Interventions (GLI): There are a total of 11 funded HIV Prevention Collaborations, all of which do at least one GLI. 10% of 11=1.1. During 2002, outcome monitoring started with one collaborations (20%), and will expand to at leas t 5 collaborations in 2003. One contractor (collaboration project) has been selected to begin outcome monitoring during 2002 and is described below.

Project No.1 - Catawba HIV Prevention Collaboration

Intervention to be evaluated: Small groups of between 15 and 20 people, enrolled in a month-long series of intervention activities each, with a minimum of two two-hour sessions, or 4 1one-hour sessions.

The sessions are targeted at adult African Women who have sex with men (heterosexuals), with IDU as a secondary target behavior. Sessions are located within or near housing communities of the intended target audience in all three counties of the Catawba Health District.

The Catawba AIDS Prevention Network (CAPN), one of the state's eleven HIV Prevention Collaborations, is the principal planning, implementation and evaluation agent of this intervention. Through local collaborative efforts, CAPN has partnered with and secured buy-in from all relevant stakeholders. Stakeholders include representatives of the intended target audience, key community figures, local sponsoring agencies/organization, local media (TV, radio and print), women's health providers, and local law enforcement. Target audience

recruitment has so far been extremely good, partly due the total involvement of the stakeholders. The group intervention package and activities currently being implemented was developed through collaboration between members of CAPN and the local chapter of the March of Dimes.

Staff are currently piloting pre and post intervention assessments. Staff have noted a challenge in measuring condom use among women at later points following the intervention (3 – 6 months) due to attrition, difficulty finding women, etc). These challenges will be addressed once the Division's evaluation consultant is hired.

Intervention Components:

- Education: STD/HIV risk-taking knowledge and attitudes
- Behavioral skills: condom use demo, role- plays (negotiation, assertiveness, etc).
- Pre-conceptual Health: basic prenatal care knowledge and attitudes, including neonatal protection against HIV infection

Data Collection: Data is being collected in three forms:

- A general pre- and post intervention knowledge and risk assessment paper and pencil survey (adapted or adopted from existing pools)
- Documented observation of participants pre- and post intervention demonstration of skills and role plays
- Paper-and-pencil after-session evaluations by participants

Data Analysis: Paper-and–pencil data will be collected using scannable forms developed in Teleform by STD/HIV evaluation staff, who will also scan received data, export such into MS Access and/or Excel, and then into *Epi Info* or *SAS* (*Statistical Analysis System*) for analysis. Comparison of pre and post intervention knowledge, attitudes and skill indicators will be analyzed.

Dissemination of data: Primary recipients of the results will be:

- Community partners (HIV Prevention Collaboration)
- Stakeholder participants (through contact info on sign-up sheets and local media)
- The HIV Prevention Community Planning Group
- Interested members of the public (through the STD/HIV Division and CAPN web sites).

Use of the data:

- As pilot for further GLIs targeting same and similar populations in similar settings
- As a basis for outcome monitoring evaluation
- As a planning tool by local providers and their partners, local health department, the statewide Community Planning Group (CPG), the STD/HIV Division, and other interested members of the public

Data will be reported to CDC by April 2003 as required.

Other Outcome Evaluation/Monitoring Activities

In addition to the group-level intervention (Catawba) that is piloting outcome monitoring during 2002, DHEC will develop additional mechanisms to conduct outcome monitoring. A committee of stakeholders will be formed by November 2002 to determine feasible measures and outcomes that will be appropriate for all prevention providers.

As described previously, the STD/HIV Division, in concert with local prevention partners and contractors, is completing development of a new monitoring and evaluation system, South Carolina Collaboration and District Evaluation System (SC CODES). SC CODES will contain a knowledge and risk assessment tool that will be linked to all applicable intervention types. Each provider will be required to complete the assessment tool before beginning and after the end of each intervention. In this way, outcome monitoring will be required of all contractors when SC CODES is launched. Data from these efforts will be accordingly analyzed, aggregated and forwarded to the CDC.

The STD/HIV Division and Bureau of Disease Control staff will re-establish an evaluation committee in November 2002. Due to staff vacancy (Ali Mansaray) and agency hiring freeze, the original committee work was postponed. The new staff person is expected to re-convene a committee comprised of local health and community based organization staff to participate in the development of an outcome monitoring plan.

b. Community Planning Evaluation: Community Planning Membership Profile

This information was requested in section II C 1 b and will not be repeated here.

c. Designing And Evaluating Intervention Plans

AIDS Health Educators (AHEDS) in the local health districts and contractors for the HIV Prevention Collaborations are required to submit Local Implementation Plans that reflect priorities in the State HIV Prevention Plan. In local health departments, staff were required to develop Operational Plans. DHEC will be developing a system for measuring the outcomes of their activities.

The collaboration contractors are required to complete Intervention Planning Forms for each of the intervention types they will conduct during the year. The Intervention Planning Form is a web-based form and mirrors the process evaluation data they will be required to collect. The Intervention Planning Form requires the contractor to indicate who is being targeted (indicating risk behavior, race/ethnicity, age, and gender), type of intervention, scientific basis of the intervention, and a detailed description of the steps in carrying out the intervention. The web-based system for planning interventions may be viewed at: www.dhec.gov/dhecapps.codes.

Staff in the STD/HIV Division review these plans and provide feedback regarding target populations and interventions.

Attachment 3 in this Application contains the CY 2003 intervention plans (aggregate) of contracted HIV prevention providers and local health department STD/HIV HE/RR staff.

d. Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Application for Funding

This information was requested in section II. D. 1 a. and is not repeated here.

e. Outcome Evaluation

The outcome evaluation plan is discussed above and includes a description and timeline of the outcome evaluation and is not repeated here.

f. Perinatal Evaluation Goals, Objectives, and Activities

Perinatal Evaluation activities are outlined in the 2002 application and focus on outcomes (proportion of pregnant women receiving HIV testing and counseling, proportion of HIV infected women receiving appropriate treatment) and process measures assessing the impact of prevention case management utilizing the recommended measures developed by CDC.

Note: South Carolina does not receive PHIPP or CCD project funds.

C. Evaluation-Related Technical Assistance

DHEC will request assistance from CDC on implementing outcome monitoring, specifically guidance on sample data collection forms, pre and post intervention assessments, and curricula for group interventions for selected populations. Additionally, assistance is requested on suggested methods for post-intervention assessments of skills learned at 3 – 6 months.

5. TECHNICAL ASSISTANCE

Technical assistance and training needs are identified through the use of ongoing evaluations of workshop programs, regular meetings of Collaborations and local public health district staff, and state CPG meetings. The following summary needs were identified for 2003:

The specific goals for TA are:

- To conduct monthly training workshops.
- To conduct bi-monthly meetings, assess needs, and provide TA to HIV Prevention Collaborations.
- To conduct quarterly meetings, assess needs, and provide TA to local health department staff.
- To assist with the planning of the annual HIV/STD Conference.
- To conduct periodic site visits and assess needs of Collaboration contractors and partners.
- To conduct periodic site visit and assess needs of local health department staff.
- To continue to collaborate with national, state, and local partners to provide training and technical assistance HIV prevention providers in South Carolina.

- To conduct the SC HIV Prevention Planning Leadership Summit in January.
- To assist the Office of Minority Health.
- To conduct on-going evaluation and needs assessment among the CPG members.
- To review quarterly reports and data available on the Collaboration and District Evaluation System (CODES) to identify needs and provide TA support.

Objectives related to these broad goals were stated in the previous section on Capacity Building and Training and will not be repeated here. The primary additional technical assistance need by the state health department during 2002 is related to determining and designing the outcome monitoring and evaluation.
There are no specific technical assistance needs at this time for the perinatal HIV prevention project.

6. SUMMARIZE UNMET NEEDS

Based on the community planning process during 2001 and 2002, the following are the priority unmet prevention service needs identified in South Carolina. The total estimated amount of additional funds to address these needs in a quality manner in all areas is $1 million.

1) Need for providing HIV counseling and testing services in alternate sites in order to reach high risk populations, and need for improved quality counseling, better risk assessment, assessment of the quality of risk reduction counseling and a review and assessment of the referral process. Data from our HIV Risk Behavior Survey of 13,525 persons indicate that fifty percent had not been tested for HIV; of those, 44.8% were not tested because they didn't think they were at risk, 13.1% were afraid to know. While some strategies for addressing this need are reflected in the Year 2003 Programmatic objectives, there is not enough local health department staff to provide these services statewide. Additionally, while there are many community partners that desire to provide counseling and testing services using Ora Sure, there are not enough resources available to support the laboratory test costs and the training and quality assurance efforts needed. Efforts will continue to address this unmet need, however with existing resources, it is likely that only the highest prevalence areas will be able to provide alternate site testing.

2) Need for expanding local capacities of minority community based organizations to address prevention needs of African American and Hispanic populations. Based on input from local HIV prevention collaborations, there is a need for funds to support diffusing effective programs provided by minority CBO's in South Carolina, and expanding and strengthening the community infrastructure of these minority organizations through building the capacities of existing staff. There are not enough resources with HIV prevention grant funds to meet this need. Staff have attempted to obtain other resources in order to address this need. For example, linking with the SCDHEC Office of Minority Health, an application for funding was submitted to support efforts to identify, develop, and leverage local, state and federal resources available to minority community based organizations that have the capacity to promote HIV prevention programs. Funding was approved but the project is only able to focus on the four counties of highest HIV prevalence. However, additional direct service funds are needed to fully expand local capacities.

A proposal was included in the agency's fiscal year 2002/2003 budget request for state funds for minority CBO's to address the disparity of HIV/AIDS. Unfortunately, this budget item is not likely to be funded due to state budget shortfalls.

3) Finally, there is a need for increased resources to provide interventions, such as prevention case management or multi-session counseling for HIV infected individuals. This need is based on needs assessments conducted by Ryan White Care providers and also supplemental surveillance surveys during FY 1998 – 2001 with HIV infected individuals indicating that there is a high level of reported unprotected sexual activity among many HIV infected individuals. In order to provide these services, additional funding will be required.

C. CONCURRENCE OF HIV PREVENTION CPG

The letter of concurrence from the statewide Community Planning Group is attached. All of the CPG members who participated in the voting process concurred without any reservations.

D. COMPLETED ASSURANCE OF COMPLIANCE WITH THE REQUIREMENTS FOR CONTENTS OF AIDS-RELATED WRITTEN MATERIALS FORM, INCLUDING WEB SITES

Completed Assurance Of Compliance With The Requirements For Contents Of AIDS-Related Written Materials Form is included with the application. All the HIV educational materials we are currently using have been approved by our program review panel. Documentation has previously been sent to CDC; the updated list of approved materials is in Attachment 4.

After receiving the HIV/AIDS web page guidelines from the CDC, the Federal Materials Review Committee issued an alert to all entities receiving CDC HIV prevention funding. The alert was followed by a phone call to the lead agency contact person requesting information regarding the existence of any HIV prevention educational web page within their collaboration and/or agency. All entities with HIV prevention educational web page(s) were told to add a disclaimer in order to comply with CDC guidelines.

The Department of Health and Environmental Control's STD/HIV Division's web site did not add a disclaimer since the information provided via the web site does not contain educational HIV prevention messages.